DHS IowaCare Presentation Slides and Additional Materials

Presentation to the Medical Assistance Projections and Assessment Council

August 31, 2005

Kevin Concannon, Director
Eugene Gessow, Medicaid Director
Iowa Department of Human Services

Why do we have IowaCare?

- Federal action to eliminate $65 million in federal revenue from Intergovernmental Transfers.
- IowaCare expands the Medicaid program on a limited basis to replace 100% State funded programs. 2/3 Federal match is received.
- Additional goal of experimenting with Medicaid reform initiatives to promote prevention, healthy activities, and personal responsibility.
- Not all of the revenue loss is replaced. Net shortfall of $12.9 million that is already built in to the FY 2006 Medicaid supplemental estimates.

Federal Approval July 1, 2005

- The 1115 federal waiver to implement IowaCare was approved July 1, 2005.
- CMS made a couple of changes to the original IowaCare proposal:
  - Increase in Nursing Facility Level of Care as State Plan Amendment, not in 1115 waiver.
  - Slight change in the funding mechanism for the HealthCare Transformation Account.
  - Phase-down of federal match for Mental Health Institutions. Need for transition plan.

Implementation Plan: July 1, 2005 – October 1, 2005

I. Medicaid Expansion – 7,337 enrolled

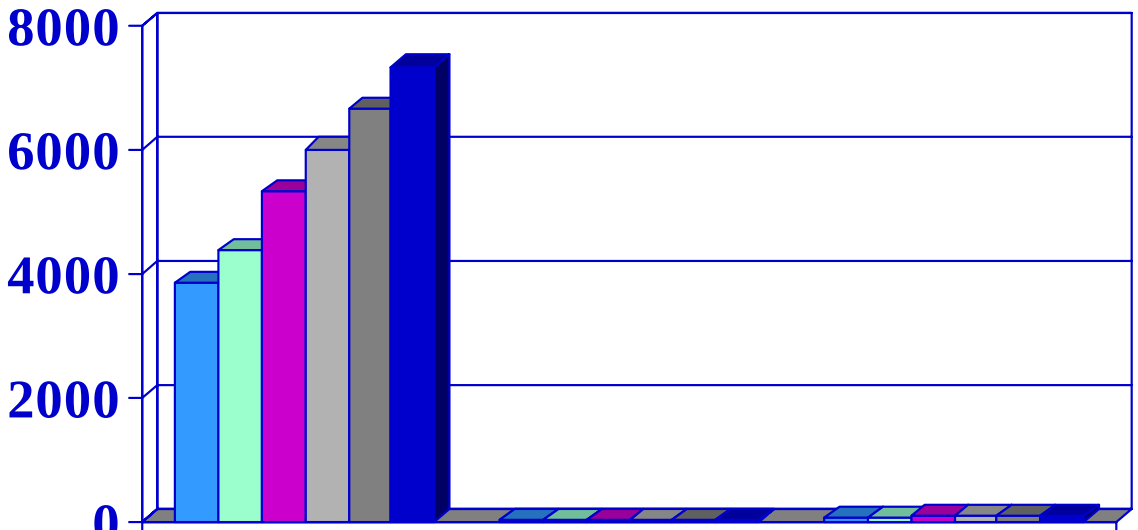
II. SED Waiver – 300 enrolled as of Oct. 1

III. Iowa Medicaid Enterprise – Operational

IV. Financial Matters – All SPAs and requests for additional information submitted. More may be requested.

V. Rebalance Long-Term Care – SPA and additional information submitted, goal to complete by Oct. 1

IowaCare Enrollment



	IowaCare	OB Group	Chronic Group
7/25/05	3857	2	50
7/28/05	4365	3	58
8/5/05	5305	7	73
8/11/05	6001	8	78
8/18/05	6647	8	86
8/25/05	7337	7	88

IowaCare Premiums (July and August 2005)

Federal Poverty Level	Premium Amount	July Billed	August Billed
Below 10%	$0.00	2554	3114
20-39%	$1.00-$3.00	316	377
40-59%	$4.00-$6.00	291	363
50-79%	$7.00-$9.00	420	513
80-99%	$11.00-12.00	580	698
100-119%	$14.00-$39.00	562	679
120-139%	$43.00-$47.00	466	545
140-159%	$51.00-$55.00	292	338
160-179%	$59.00-$63.00	206	252
180-200%	$67.00-$75.00	149	181
Unassigned	$0.00-$75.00	12	14

*Total members enrolled with no premium due

July and August premiums due 8/31/05

IowaCare Activities

- Member Services has received 1131 calls regarding IowaCare. (see handout)
- Provider Services has received 5 calls regarding Iowa Care. All are calls wanting to know if a service is covered.
- The telephone eligibility line (ELVS) has received over 20,000 Eligibility Inquiries on Iowa Care members. 19,569 of the transactions were from UIHC and Broadlawns.
- Pharmacy Point of Sale has received approximately 100 calls. Calls are generally about member eligibility, where members can get prescriptions filled, and concerns about the adequacy of prescription coverage under IowaCare.
- See tabs #9, 10 and 15 of binder for copies of the application, letter to State Papers members, letter to County General Relief Directors, and provider information letters.

Payments to UIHC, Broadlawns and State MHIs

- The first two of 12 monthly payments were made to all covered providers as of July 7, 2005 and August 1, 2005. A third payment is being made this week.
- Total Payments = $22.5 million

	UIHC	Broadlawns	MHIs
Total	$6.8 million	$9.2 million	$6.5 million

Question: What does “run out of money” mean?

- Providers will get 12 monthly payments in full.
- No supplemental appropriation for IowaCare will be requested.

- UIHC, Broadlawns and MHIs have responsibility to provide indigent health care independent of IowaCare Act.
- The amount appropriated to UIHC and MHIs for FY 2006 is intended to equal the amount appropriated for indigent care in FY 2005. Amount appropriated for Broadlawns is intended to exceed it by $3 million dollars.

Question: What does “run out of money” mean?

- So what does run out of money mean?
- Costs do not equal the appropriation. Need baseline FY 2005 cost data for each provider to determine when same level has been provided in FY 2006.
- Will monitor costs, enrollment, and cost per person to manage within the amount appropriated. Do not expect that closing enrollment in IowaCare will result in decreases in indigent care since that obligation is independent of IowaCare.

Implementation Plan: October 1, 2005 – March 1, 2006

I. Mental Health Transformation Pilot

II. MR/DD – Physical health and Case-mix

III. Oral Health – Dental Home

IV. Iowa Medicaid Enterprise II (Well run managed care organization – see appendix)

Implementation Plan: October 1, 2005 – March 1, 2006

V. Research

- State of health insurance
  - barriers to access
- Role of Indigent Care
  - Amount, scope, location, extent of public tax funding

Implementation Plan: October 1, 2005 – March 1, 2006

VI. Performance Reporting

- Who is being covered? What are their characteristics?
- For what services?
- How much does it cost?
- What gaps are there?
- Impact on indigent care and uninsured?
- Impact on health status?
- How many pay premiums/hardship exemptions vs. no response?
- Level of customer satisfaction?

IowaCare Data Reporting

- Plan to collect the following data monthly for IowaCare:
  - Enrollment by county and by program
  - Denials
  - Age, gender, income status
  - Premiums billed, collected, hardships, no response
  - Claims paid by provider, by service category
  - Cost per member, type of services provided
  - Number who apply for IowaCare but are eligible for Medicaid
- Is there other data the committee would like to see?

Appendix
IME II – Well Run Managed Care Organization

- Health Prevention and Promotion
  - Smoking cessation, weight loss, IowaCare medical exams, 24-hour hotline, co-payment incentives
- Partnership with Providers
  - Care management, Electronic Medical Records, Provider Incentive Payments
- Utilization Management
  - Non-Rx prior authorization, clinical care committee
- Learning Organization
  - Best practices, provider and member education
- Price Sensitive
  - Pricing commission

IowaCare Reporting Requirements

Overview

The IowaCare Medicaid expansion is part of House File 841 approved by the Iowa Legislature in 2005. The group includes adults under 200% of the Federal Poverty Level who are not otherwise covered by insurance for needed medical care.

The objective of the reports is to identify the level of interest in the program, and monitor the program to ensure the demand does not exceed the State and Federal governments' ability to provide funding for care.

Assumptions

- The programs of primary interest are the IowaCare group (Adults <= 200% of FPL), IowaCare OB/Newborn (Pregnant woman under 300% FPL with medical costs that reduce the level of income to 200% or less) , and Continuous care for chronically ill citizens who were previously on State papers.
- The reports do not cover the Family Planning Waiver
- The reports do not cover the Children's Mental Health waiver.
- The reports will all be made available on the public website.

Requirements

1. Provide Monthly and YTD totals by county for the IowaCare applications.

Desired Measures:

Column	Source Data
Applications Received	Not Available
Applications Approved	MMIS Eligibility or Title 19 Eligibility Aid Type 60-E or 60-P
Applications Denied	Waiting for data from IABC will be building this information from forms file on a regular basis.
Denied Over Income Chronic Condition Approval	MMIS Eligibility or Title 19 – Aid Type 777
Pending	N/A or Manual
Eligible for a Medicaid Program	N/A or Manual

- Group by: County, with a grand total at the bottom of the report
- Order by: County Name

IowaCare Reporting Requirements

- Freshness of Data: Eligibility – Minimum weekly
- Format: Table with a row for each county and data in the columns
- Filters – each as separate report – so don't combine filters:
  - Gender
  - Age (19-20, 21-29, 30-39, 40-49, 50-59, 60-65)
  - Federal Poverty Level (not sure if available yet)

Enrollment Table Elements

FY	Nov
County	Dec
Aid Type	Jan
Gender	Feb
Age Range	Mar
July	Apr
Aug	May
Sep	Jun
Oct	Total

Denial Table Elements

FY	Nov
County	Dec
Aid Type	Jan
Gender	Feb
Age Range	Mar
July	Apr
Aug	May
Sep	Jun
Oct	Total

IowaCare Reporting Requirements

Report 1

IowaCare Enrolled Members

	July	Aug	Sep	Oct	…..	May	June	Total
Adair	999	999	999	999		999	999	999
…								
Wapello								
Total	xxx	xxx	xxx				xxx	xxx

Report 2

YTD Enrollment

	IowaCare	OB/Newborn	Denied Over Income	Denied
Adair	999	999	999	999
….				
Wapello	999	999	999	999
Total	999	999	999	999

IowaCare Reporting Requirements

2. Premium Reporting

Desired Measures:

1) Percentage of people with zero premium (and count)
2) Percentage of people with premiums > than zero who have paid, declared hardship, not responded … for each month of premium due. (Starts August, 2005) (and counts)
3) Total premiums collected
4) YTD total percent of people (and count) who have claimed hardship at least one month.
5) YTD total percent of people who have claimed hardship for all months.
6) YTD total percent of people who have never claimed hardship.

Data Source - Iowacare Premium System .

We should also consider a detailed drill down that shows the same results based upon premium amount to reflect if the percentage of hardships go up as the premium amounts go up, or if the higher premium (and theoretically higher FPL – allows the client more ability to pay.)

Group by Month
Data Freshness: Monthly
Format: This information could be presented in a table format – or in a series graphs

1) A pie graph showing the premium amount and percent in relationship to the pie.
2) A stacked bar chart showing the premium amount on the x axis and then stacking – %paid, %hardship, and %unpaid. (YTD)
3) A stacked bar chart showing the month on the bottom and the total premium amount paid each month

Filters:

Gender
Ages

IowaCare Reporting Requirements

3. Claims paid for IowaCare

Desired Measure:

For each of the providers show Monthly (1st date of service) and YTD dollars in claims paid .

- Cherokee
- Independent
- Mt. Pleasant
- Clarinda

– UIHC Pharmacy
– UIHC Hospital
– Ambulance
- UIHC DME / Supplies

– Broadlawns Hospital
– Broadlawns Physician Group
- Broadlawns Dentist

Suggestions:

- It might be helpful to show the dollars spent YTD in relationship to the amount allocated to the institution.... But for this purpose you'd want to break out by aid type so that the DSH dollars reflect separately.
- Allow filters by AID type (60E - IowaCare, 60P – IowaCare OB/Newborn , 777 – DSH)
- Report the total dollars claimed for the 60-P group – regardless of the institution.
- Show the average length of days between last day of service and the claim submission date.

4. Cost Per Member

Review the claims and determine the average cost per member for each of the aid types based upon claims submitted YTD.

5. Months of Participation for IowaCare (60E)

Note – this will not be meaningful data until at least December, Jennifer has requested a preliminary version for the implementation plan so build the framework for this report.

Desired Measure:

Overall: The 12 month enrollment period, the number of months a person was enrolled.
People with no premium obligation or who claimed hardship , the number of months a person was enrolled.
People with premium obligation or who claimed hardship, the number of months a person was enrolled.
Number of people who have started on the program since July 1 and are still active.
Number of people who started on the program since July 1 but are closed.
- display the data by length of months active, filter by premium vs. no premium.
Reasons for Disenrollment – (Do we have this information?)

For this measure we need to find a way to clarify people who enrolled in July 2005, vs. someone who enrolled after that – it might be that in July 2006 – we begin a look at people who started in July 2005 – and do rolling statistics, etc. We will likely want to start looking at this prior to July 2006 –

6. Provide Month and YTD counts of distinct recipients on Medicaid

ON HOLD 8/12/05 - this has not been determined to be a priority yet.

- *Need to determine if we count any eligible – or if there are selected AID types that should be bypassed before proceeding.*

Desired Measures

Column	Source Data
Count of approved members	MMIS Eligibility or T19 Eligibility

- Group by: County, with a grand total at the bottom of the report
- Order by: County Name
- Freshness of Data: Monthly
- Format: Table with a row for each county and data in the columns ; This would be a good candidate for a bar graph show growth or trends would be visible.
- Filters:
  Gender
  Age (19-29, 30-39, 40-49, 50-59, 60-65)
  Ethnicity

Would it be helpful or interesting to show a combined table of IowaCare and Medicaid – and in addition to showing counts of recipients YTD – show the percentage of the population in the county - for example Polk

IowaCare Reporting Requirements

County as 50% of the IowaCare members and 33% of the total Medicaid members. This would allow a quick comparison so show if the IowaCare population is spread geographically similarly to the overall population of Medicaid.

Member Services IowaCare Calls
(7/18/05-8/26/05)

Type of Call	Number of IowaCare Calls Received
Type of Service Offered	606
Premium	183
Pharmacy	123
*Duplicate Billing	62
Application	42
Access	39
Miscellaneous (Hardship, Transportation, Dental, Location, Co-Pay, IowaCare Card)	76
TOTAL	1131

*Duplicate premium billing statements were sent out to approximately 500 members.

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-001	Trotter	Att. 1.2-A, page 1	X	A	1/1/2005	1/18/2005	Approved	2/3/2005	Table of Organization – NO
MS-05-002	Trotter	Att. 1.2-D, page 2	X	A	1/1/2005	2/1/2005	Approved	5/3/2005	Addition of coverage groups (MEPD, buck-supp & BCCT) – NO
MS-05-003	Parker	Att 4.19-B, page 7	X		1/15/2005	Faxed & mailed 3/29/2005			Simplify & clarify rule on drug pricing – NO
MS-05-004	Keen	Att 4.19-B, Page 49A	X		7/1/2005	6/27/2005			Payments to public hospitals will not exceed costs-outpatient services. See also TN MS-05-005 – NO

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-005	Keen	Att 4.19-B, Page 49A	X		6/30/2005	6/27/2005			Eliminate hospital upper payment limit payments – outpatient services. See also TN MS-05-004 – YES ($7,400,000)
MS-05-006	Ernst-Becker	Att 4.19-A, Page 26c, 26d, 26e, 28a, 28b, 29	X		6/30/2005	6/27/2005			Eliminate the mechanisms to receive supplemental disproportionate share hospital payments and supplemental indirect medical education funds. Implement new methodology to reimburse hospitals for enhanced disproportionate share and graduate medical education payments. – NO
MS-05-007	Keen	Att 4.19-A, Page 13	X		6/30/2005	6/27/2005			Eliminate hospital upper payment limit payments-inpatient services. – YES ($16,500,000)

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-008	Keen	Att 4.19-A, Page 26f, 27, 28	X		6/30/2005	6/27/2005			Payments of public hospitals will not exceed costs-inpatient services. – NO
MS-05-009	Keen	Att 4.19-A, Page 2, 4a, 8, 8a, 9, 10a, 15	X		6/30/2005	6/27/2005			Eliminates the payment to be added on to the blended base amount for Iowa state-owned hospitals with over 500 meds to adjust for the high cost incurred for providing services to medical assistance patients. – YES ($13,700,000)
MS-05-010	Ernst-Becker	Att 4.19-B, Page 28	X		6/30/2005	6/27/2005			The proposed changes are being made to eliminate a physician services supplemental payment adjustment to publicly owned acute care teaching hospitals. – YES ($13,500,000)

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-011	Parker	Att 4.18-A, Page 1 OMB No.: 0938-0193; Att 4.18-C, Page 1 OMB.: 0938-0193	X		7/1/2005	6/27/2005	Approved	8/5/2005	The legislatively mandated changes are being made to require modified copayments for prescribed drugs. Generic and preferred brand-name drugs are $1.00 while non-preferred brand-name drugs range from $1.00 to $3.00 depending on the cost to the state. For this purpose, any brand-name drug not subject to prior approval based on non-preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug. – YES '05 = $381,165 and '06 = $1,564,250

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-012	Steenblock	Att 4.19-D, Page 20	X		7/1/2005	6/27/2005			Revise the nursing facility level of care criteria for facility admission, and maintain current level of care criteria for home and community based services for nursing facility level of care. – NO
MS-05-013	Parker	Att 4.19-B, Page 7	X		6/25/2005	6/27/2005	Approved	8/9/2005	This amendment makes a technical change to the source of data file used in determining Medicaid drug reimbursement. A new contract for pharmacy claims processing takes effect on 6/25/05, and the new vendor uses a different source of pharmacy data. The new source, Medi-Span replaces the existing source First DataBank. – NO

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-014	Ernst-Becker	Att. 4.19-A, Page 6, 32, 33			7/1/2005	8/5/2005			IowaCare Prospective Interim Payment – YES - '06 = $57,350,009 and '07 = $56,425,469
MS-05-015	J. Steenblock	Att. 4.19-D, Page 2b, 2c, 7			7/1/2005	8/5/2005			Payments to public nursing facilities will not exceed costs. This SPA deletes IGT language and replaces language that payment will not exceed costs to public nursing facilities. YES - '05 = ($1,363,455) and '06 = ($5,453,818)
MS-05-016	Kazor	Att 3.1-A, Page 3, 4, 5, 6, 7			7/1/2005	8/5/2005			Adds a new population group to target group2 in the state plan. This group is only children approved for the CMH Waiver - YES – '05 = $328,113.00 '06 = $1,303,344.00

Transmittal Number	Program Person	Plan Pages	Reported to Sue Lerdal as:		Effective Date	Status			Description and Comments Fiscal Impact – YES/NO
			Sent	Approved Denied Withdrawn		To K.C.	Approved or Denied	Date Approved	
MS-05-017	Keen	Att 4.19-A, Page 23, 24, 25, 26b			7/1/2005	8/8/2005			Implements a 3% increase in payments to qualifying hospitals from the Graduate Medical Education and Disproportionate Share Fund. – YES '06 = $24,750,123 and '07 = $25,604, 442
MS-05-018	Keen	Att 4.19-B, Page 1, 2, 2a, 6b, 7a			7/1/2005	8/8/2005			Implements a 3% increase in reimbursement rates for Iowa Medicaid providers as authorized by 2005 Iowa Acts. Dispensing fee for pharmacists is increased by 3%. The max. reimbursement rate for PMICs is increased to $156.03 per day. – YES '06 = $3,627,981 and '07 = $4,573,415

IowaCare Enrollment as of 8/26/05

County	IowaCare OB NewBorn DSH	Percent of IowaCare Population	Medicaid Population 19-64	Percent of Medicaid Population 19-64
ADAIR	7	0.09%	188	0.17%
ADAMS	2	0.03%	168	0.15%
ALLAMAKEE	11	0.15%	416	0.38%
APPANOOSE	29	0.39%	1006	0.93%
AUDUBON	7	0.09%	136	0.13%
BENTON	33	0.44%	674	0.62%
BLACK HAWK	228	3.06%	6165	5.68%
BOONE	48	0.65%	1010	0.93%
BREMER	29	0.39%	482	0.44%
BUCHANAN	43	0.58%	662	0.61%
BUENA VISTA	10	0.13%	543	0.50%
BUTLER	17	0.23%	432	0.40%
CALHOUN	14	0.19%	291	0.27%
CARROLL	32	0.43%	735	0.68%
CASS	12	0.16%	701	0.65%
CEDAR	37	0.50%	375	0.35%
CERRO GORDO	76	1.02%	1981	1.82%
CHEROKEE	49	0.66%	413	0.38%
CHICKASAW	22	0.30%	359	0.33%
CLARKE	27	0.36%	394	0.36%
CLAY	20	0.27%	552	0.51%
CLAYTON	32	0.43%	537	0.49%
CLINTON	157	2.11%	2772	2.55%
CRAWFORD	19	0.26%	635	0.58%
DALLAS	48	0.65%	917	0.84%
DAVIS	9	0.12%	274	0.25%
DECATUR	11	0.15%	472	0.43%
DELAWARE	29	0.39%	549	0.51%
DES MOINES	113	1.52%	2236	2.06%
DICKINSON	27	0.36%	389	0.36%
DUBUQUE	148	1.99%	2971	2.74%
EMMET	7	0.09%	261	0.24%
FAYETTE	29	0.39%	899	0.83%
FLOYD	49	0.66%	770	0.71%
FRANKLIN	21	0.28%	336	0.31%
FREMONT	13	0.17%	291	0.27%
GREENE	6	0.08%	343	0.32%
GRUNDY	30	0.40%	201	0.19%
GUTHRIE	14	0.19%	293	0.27%
HAMILTON	29	0.39%	512	0.47%
HANCOCK	14	0.19%	250	0.23%
HARDIN	35	0.47%	534	0.49%
HARRISON	12	0.16%	572	0.53%
HENRY	83	1.12%	725	0.67%
HOWARD	9	0.12%	221	0.20%
HUMBOLDT	10	0.13%	347	0.32%
IDA	5	0.07%	196	0.18%
IOWA	36	0.48%	392	0.36%
JACKSON	56	0.75%	725	0.67%
JASPER	81	1.09%	1195	1.10%
JEFFERSON	56	0.75%	827	0.76%

County	IowaCare OB NewBorn DSH	Percent of IowaCare Population	Medicaid Population 19-64	Percent of Medicaid Population 19-64
JOHNSON	269	3.62%	3074	2.83%
JONES	41	0.55%	545	0.50%
KEOKUK	27	0.36%	443	0.41%
KOSSUTH	21	0.28%	475	0.44%
LEE	155	2.08%	1909	1.76%
LINN	366	4.92%	7361	6.78%
LOUISA	27	0.36%	408	0.38%
LUCAS	18	0.24%	475	0.44%
LYON	9	0.12%	193	0.18%
MADISON	24	0.32%	331	0.30%
MAHASKA	68	0.91%	1054	0.97%
MARION	77	1.03%	923	0.85%
MARSHALL	53	0.71%	1747	1.61%
MILLS	17	0.23%	812	0.75%
MITCHELL	11	0.15%	237	0.22%
MONONA	18	0.24%	364	0.34%
MONROE	29	0.39%	366	0.34%
MONTGOMERY	12	0.16%	582	0.54%
MUSCATINE	156	2.10%	1878	1.73%
OBRIEN	19	0.26%	522	0.48%
OSCEOLA	4	0.05%	105	0.10%
PAGE	29	0.39%	721	0.66%
PALO ALTO	13	0.17%	283	0.26%
PLYMOUTH	7	0.09%	563	0.52%
POCAHONTAS	12	0.16%	222	0.20%
POLK	2,912	39.14%	15368	14.15%
POTTAWATTAMIE	75	1.01%	3974	3.66%
POWESHIEK	40	0.54%	614	0.57%
RINGGOLD	8	0.11%	204	0.19%
SAC	12	0.16%	288	0.27%
SCOTT	309	4.15%	7143	6.58%
SHELBY	16	0.22%	391	0.36%
SIOUX	14	0.19%	513	0.47%
STORY	105	1.41%	1664	1.53%
TAMA	32	0.43%	442	0.41%
TAYLOR	13	0.17%	226	0.21%
UNION	27	0.36%	620	0.57%
VAN BUREN	19	0.26%	304	0.28%
WAPELLO	145	1.95%	2572	2.37%
WARREN	37	0.50%	884	0.81%
WASHINGTON	53	0.71%	625	0.58%
WAYNE	6	0.08%	289	0.27%
WEBSTER	77	1.03%	1939	1.79%
WINNEBAGO	19	0.26%	315	0.29%
WINNESHIEK	27	0.36%	431	0.40%
WOODBURY	40	0.54%	4235	3.90%
WORTH	15	0.20%	178	0.16%
WRIGHT	16	0.22%	438	0.40%
	7,440	100.00%	108,575	100.00%

WAIT LIST AS OF AUGUST 26, 2005

	All Waivers	AIDS/HIV	BI	CMH	IH	MR State Case	MR Child	PD
Number on wait list as of 7/1/05	**2497**	20	501		1227	62		687
Number on wait list as of 8/26/05	**2576**	31	379	38	1178	66	133	751

SLOTS THAT HAVE BEEN RELEASED TO THE FIELD

Total number of slots released to date: **805**

July 1, 2005 - **200** slots released

August 15, 2005 - **500** additional slots released

105 Number of slots that have been closed (96) or consumers enrolled for services (9). Once closed or enrolled, a new slot is released.

September 1, 2005 - **500** additional slots will be released

CURRENT SLOT ACTIVITY

	All Waivers	AIDS/HIV	BI	CMH	IH	MR State Case	MR Child	PD
Total number of enrolled consumers	**9**	0	2		6	1		
Total number of slots assigned, but **not** been pended	**521**	1	93		284	12		131
Total number assigned that **have been** pended	**173**	0	83		55	1	1	33
Number of slots closed	**96**		52		38	1		5
Number of slots temporarily closed for 90 day (Due to possible appeal)	**6**		3		3			
TOTAL	**805**	1	233		386	15	1	169

CLOSED SLOTS

Reasons for closure:								
No Response within 30 days	**18**		13		4			1
Did not meet LOC	**2**		2					
Income variables	**1**		1					
Death	**14**		4		9			1
Do not meet waiver eligibility	**2**							2
In a facility	**4**		1		3			
Chose another waiver	**14**		5		9			
Moved out of state	**4**				3	1		
Unknown reason	**12**		9		3			
Slots withdrawn	**25**		17		7			1

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

James Scott
Centers for Medicare and Medicaid Services
Regional Office 7
Richard Bolling Federal Building, Room 235
601 East 12th Street
Kansas City, MO 64106

August 30, 2005

SUBJECT: Iowa Medicaid State Plan Amendment – SPA 05-012

Dear Mr. Scott:

The purpose of this letter is to provide additional information related to SPA 05-012, which revises the nursing facility level of care criteria for facility admission and maintains the current level of care criteria for home and community based services for nursing facility level of care.

With this SPA, the level of care requirement for new admissions to receive services in a nursing facility is increased. In other words, a new admission to a nursing facility must have greater care needs then currently required in order to qualify for Medicaid payment. The home and community based services (HCBS) level of care, (the current nursing facility level of care in a nursing facility), will continue to be the nursing facility level of care criteria used for HCBS. If an individual is applying for services in a nursing facility and meets the HCBS level of care criteria and HCBS services are not immediately available in the community, or if community services have been used for one year and the individual chooses to then enter a nursing facility, then that lower level of care will qualify the individual for nursing facility services. This SPA was submitted on June 27, 2005.

SPA Approval Appropriate
House File 841, enacted by the 2005 Iowa Legislature, directs the Department to seek a state plan amendment establishing a new level of care standard for nursing facility services. CMS has raised the issue of whether the proposed state plan amendment limits access to a mandatory service.

The State recognizes that nursing facility services are mandatory Medicaid services, pursuant to Sections 1902(a)(10)(A) and 1905(a)(4)(A) of the Social Security Act. But that does not mean that nursing facility services must be available on demand, regardless of need. On the contrary, the Social Security Act also mandates that states "provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services." Section 1902(a)(30)(A). Federal Medicaid regulations explicitly provide that a state "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d). Regarding nursing facility services, the regulations further require that before payment can be authorized, an interdisciplinary team of health professionals must make a comprehensive evaluation of the need for nursing facility services, including an evaluation of "the resources available in the home, family, and community." 42 C.F.R. § 456.370(a), (c)(7).

The proposed state plan amendment updates Iowa's standard for determining the need for nursing facility services by explicitly taking into account home and community-based services, where they are available and whether they can meet the individuals needs. The fact that home and community-based services are not mandatory Medicaid services should not preclude the state from considering them in determining the need for nursing facility services. As noted above, the regulations require consideration of "the resources available in the home, family and community," without regard to whether those services would be paid for by Medicaid, either as mandatory or optional services. Further, the federal regulations also provide as follows:

> If the comprehensive evaluation recommends ICF [nursing facility] services for an applicant or recipient whose needs could be met by alternative services that are currently unavailable, the facility must enter this fact in the recipient's record and begin to look for alternative services. 42 C.F.R. § 456.371.

This requirement assumes that if alternative services were available, nursing facility services would not have been approved. And it makes no distinction based on whether the alternative services are mandatory Medicaid services, optional Medicaid services, or non-Medicaid services.

The proposed state plan amendment also satisfies the requirement of state-wideness as set forth in Section 1902(a)(1) (42 U.S.C. § 1396A(a)(1). The standards for determining nursing facility level of care will be applied uniformly throughout the state. While it is true that the same community-based services may not be available everywhere, there is no requirement that the Medicaid program make services equally available in the state. Rather, the relevant requirement is that the state's payments to providers must be "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population. 42 C.F.R. 447.204. As long as home and community-based waiver services are available to Iowa recipients to the same extent that they are available to the general population, that requirement is met. Furthermore, the needs of all recipients will be met one way or another. If waiver services are not available, nursing facility services will be provided.

The State does intend to actively promote the development of home and community-based services throughout the state.

The Department submits that its proposed state plan amendment, which takes into account the availability of home and community based services in determining the need for nursing facility services, is consistent with its obligation under the Social Security Act to safeguard against unnecessary utilization of nursing facility services.

Implementing the SPA
Iowa will continue using the current level of care determination and assessment process used in the state.

Current Process and Assessment Instrument Used
Iowa Medicaid determines level of care (medical necessity) for Medicaid-eligible members for identified Medicaid programs. This independent pre-admission screening for long-term care services includes an onsite assessment by licensed nurses in the state of Iowa, who have backgrounds in long-term care, mental health/mental retardation and home health.

This process provides a consistent assessment and evaluation process for all Iowa Medicaid members seeking or receiving long-term care services.

The Iowa Medicaid Enterprise (IME) nurse review staff will continue to use the same process in place to determine level of care and continue to use the same assessment tool, to assess needs under the new criteria proposed in SPA 05-012. Members will have the ability to appeal the determinations made for level of care utilizing the new criteria, just as they do today, by receiving a notice of decision for the medical necessity, which will inform them of their appeal rights.

By utilizing the existing level of care process, we will ensure that the new criteria will be applied consistently statewide, although the availability of HCBS services may vary across the state. Under this SPA, once the level of care requirement is met, it is necessary to determine if HCBS services are available. The nurse reviewers will do this determination of availability of services. If HCBS services are not immediately available, members will be eligible to receive nursing facility services.

Ongoing Service Need Identification

Level of care assessments are completed prior to admission to a nursing facility or if currently residing in a nursing facility and requesting Medicaid funding. Re-assessments are completed once residing in the facility for 90 days. The reassessment is done to re-evaluate the level of care need and to provide options for a member who may want to return to their home. A re-assessment would also be completed if there were a significant change in the member's condition. For HCBS members, assessments are completed upon application for HCBS services, and a re-assessment is completed annually and as there are significant changes in the member's condition. If at any time the support system for a member receiving community-based services changes, or if services are no longer available in the community, or if the person no longer requires them, a re-assessment can be requested and completed by the IME nurse reviewers. In instances where a member meets the medical necessity criteria for HCBS and has received HCBS services in the community for one year but now chooses to receive nursing facility services, Iowa will allow the member to receive nursing facility services funded by Medicaid. With this SPA, the periodicity of assessments does not change.

Nursing Facility Program Entitlement and Utilization Management Tool

Nursing facility services will continue to remain an entitlement if home and community-based waiver services are unavailable due to limitation on slots. The state Medicaid program will pay for nursing facility services needed in the absence of home and community based services.

A process is being developed to track members who are admitted to nursing facilities when services are not immediately available in the community. This process will include the IME nurse review staff following up with the members, family members and facility staff on the desire for community-based services and status of service availability in the community to meet the member's needs. It is our intent to promote the development of HCBS services in the state to ensure HCBS availability statewide for members who choose the HCBS waiver programs for their long-term care needs.

With these new criteria there is no increased incentive for individuals to seek waiver services. We do not expect a "woodwork" effect for HCBS, but we do expect to use this as a new utilization management tool to allow us to use waiver services where available. The state will

continue to assure quality standards are being met by reviewing the new level of care criteria and assessment process.

SPA Effective Date
Though the effective date of the SPA is July 1, 2005, the state plans to implement the new level of care criteria prospectively after approval of the SPA. We will notify all stakeholders of the implementation date, and it will not be retroactive to July 1, 2005. We will continue to use the current criteria until an established implementation date, following CMS approval.

SPA Ongoing Analyses
We expect to report quarterly and no less often than annually to the legislature on this statutory change. We will share the legislative reports and any analysis completed with CMS.

Ensure Continuity of Care
With the implementation of the new level of care criteria, eligible members will not experience any break in their services, or any delay in receiving the needed services. The intent is to allow a smooth transition from hospital services to nursing facility care or waiver services, whichever may be applicable. The state recognizes that for some individuals, until services are available in the community, the nursing facility care will be provided. This new level of care broadens the scope of services that will be made available to the member.

Additional Supporting Information
Attachments enclosed with this letter include:

1. Responses to the five standard funding questions CMS is now asking on all reimbursement SPAs.
2. State Statute (House File 841) section that authorizes the changes in level of care.
3. Assessment tool used to determine level of care in nursing facilities.
4. HCBS Waiver amendments to identify the level of care in a nursing facility is different than nursing facility level of care for the HCBS waivers (AIDS/HIV, Brain Injury, Elderly, Ill & Handicapped and Physical Disability).
5. Annual Nursing Facility Characteristics report completed by the Iowa Foundation for Medical Care in September 2004. This report identifies residents in nursing facilities that have minimal care needs. See pages 6 and 7 of this report.

Please direct any questions regarding this SPA to Jennifer Steenblock at jsteenb@dhs.state.ia.us or (515) 725-1299, or Dan Hart, Assistant Attorney General, at dhart1@dhs.state.ia.us or (515) 281-4672.

Sincerely,

Eugene I. Gessow
Medicaid Director

Enclosures

Cc: Mandy Hanks, CMS Kansas City Regional Office
Steve Hrybyk, CMS Central Office

ALTH CARE FINANCING ADMINISTRATION

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 5 — 0 1 2

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

O: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2005

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 06 $ 0
b. FFY 07 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D
Page 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D
Page 20

10. SUBJECT OF AMENDMENT:
Revise the nursing facility level of care criteria for facility admission, and maintain current level of care criteria for home and community based services for nursing facility level of care.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kevin W Concannon

13. TYPED NAME:
Kevin W. Concannon

14. TITLE:
Director

15. DATE SUBMITTED:
June 27, 2005

16. RETURN TO:
Director
Department of Human Services
1305 E. Walnut
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

K. Nursing Facility Level of Care

1. The individual was admitted to a nursing facility on or after July 1, 2005, and based upon the minimum data set, the individual requires limited assistance, extensive assistance, or has total dependence on assistance, provided by the physical assistance of one or more persons, with three or more activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems," or

2. Based upon the minimum data set, the individual requires supervision or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems," and

   a. No medically appropriate waiver services adequate to meet their needs are available in the community, or

   b. The individual has received waiver services in the community for one year and chooses to enter a nursing facility, or

   c. The individual was admitted to a nursing facility prior to July 1, 2005.

3. Based on the minimum data set, the individual requires the establishment of a safe, secure environment due to moderate or severe impairment of cognitive skills for daily decision making, or

4. The individual has established a dependency requiring residency in a medical institution for more than one year.

BMJ

clinical evidence

concise

The international source of the best available evidence for effective health care

13
SUMMER 2005

Atrial fibrillation (acute)

heart disease, hypertension, heart failure, valve disease, diabetes, alcohol abuse, thyroid disorders, and disorders of the lung and pleura.[1] In a British survey of acute hospital admissions of patients with atrial fibrillation, a history of ischaemic heart disease was present in 33%, heart failure in 24%, hypertension in 26%, and rheumatic heart disease in 7%.[3] In some populations, the acute effects of alcohol explain a large proportion of the incidence of acute atrial fibrillation. Paroxysms of atrial fibrillation are more common in athletes.[6]

PROGNOSIS **Spontaneous reversion:** Observational studies and placebo arms of RCTs have found that more than 50% of people with acute atrial fibrillation revert spontaneously within 24–48 hours, especially if atrial fibrillation is associated with an identifiable precipitant such as alcohol or myocardial infarction. **Progression to chronic atrial fibrillation:** We found no evidence about the proportion of people with acute atrial fibrillation who develop more chronic forms of atrial fibrillation (e.g. paroxysmal, persistent, or permanent atrial fibrillation). **Mortality:** We found little evidence about the effects on mortality and morbidity of acute atrial fibrillation where no underlying cause is found. Acute atrial fibrillation during myocardial infarction is an independent predictor of both short term and long term mortality.[7] **Heart failure:** Onset of atrial fibrillation reduces cardiac output by 10–20% irrespective of the underlying ventricular rate[8,9] and can contribute to heart failure. People with acute atrial fibrillation who present with heart failure have worse prognoses. **Stroke:** Acute atrial fibrillation is associated with a risk of imminent stroke.[10–13] One case series used transoesophageal echocardiography in people who had developed acute atrial fibrillation within the preceding 48 hours; 15% had atrial thrombi.[14] An ischaemic stroke associated with atrial fibrillation is more likely to be fatal, have a recurrence, and leave a serious functional deficit among survivors than a stroke not associated with atrial fibrillation.[15]

Please refer to the Clinical Evidence website for full text and references.

Changing behaviour

Search date September 2003

Margaret Thorogood, Melvyn Hillsdon, and Carolyn Summerbell

What are the effects of interventions aimed at changing people's behaviour?

BENEFICIAL

Advice from physicians and trained counsellors to quit smoking

Systematic reviews have found that simple, one off advice from a physician during a routine consultation increased the number of smokers quitting smoking and not relapsing for 1 year. One systematic review found that advice from trained counsellors also increased quit rates compared with minimal intervention.

Advice on a cholesterol lowering diet

Systematic reviews have found that advice on a cholesterol lowering diet (i.e. advice to lower total fat intake or increase the ratio of polyunsaturated : saturated fatty acid) leads to a small reduction in blood cholesterol concentrations in the long term (≥ 6 months).

Advice on reducing sodium intake to reduce blood pressure

One systematic review found that, compared with usual care, intensive interventions to reduce sodium intake provided small reductions in blood pressure, however effects on deaths and cardiovascular events are unclear.

Antidepressants (bupropion or nortriptyline) as part of a smoking cessation programme (but no evidence of benefit for selective serotonin reuptake inhibitors or moclobemide)

Systematic reviews have found that quit rates are increased by bupropion and nortriptyline given as part of a smoking cessation programme, but not by moclobemide or selective serotonin reuptake inhibitors.

Antismoking interventions in people at high risk of disease (evidence that counselling or bupropion are effective in this group)

Systematic reviews and four subsequent RCTs have found that antismoking advice improves smoking cessation in people at high risk of smoking related disease. We found no evidence that high intensity advice is more effective than low intensity advice in high risk people. One RCT found that bupropion increased cessation rates in smokers with cardiovascular disease.

Antismoking interventions for pregnant women

Two systematic reviews have found that antismoking interventions in pregnant women increased abstinence rates during pregnancy. One RCT found that nicotine patches did not significantly increase quit rates in pregnant women compared with placebo.

Exercise advice to women over 80 years of age

One RCT found that exercise advice delivered in the home by physiotherapists increased physical activity and reduced the risk of falling in women over 80 years.

Lifestyle interventions for sustained weight loss

Two large RCTs found that weight loss advice resulted in greater weight loss than no advice. One RCT found that cognitive behavioural therapy was more effective than usual care in promoting weight loss. Systematic reviews have found that using behavioural therapy to support advice on diet and exercise is probably more effective in achieving weight loss than diet advice alone. One systematic review

Changing behaviour

found limited evidence that partial meal replacement plans reduced weight loss at 1 year compared with reduced calorie diet in people who completed the treatment.

Nicotine replacement for smoking cessation

One systematic review and one subsequent RCT have found that nicotine replacement is an effective additional component of cessation strategies in smokers who smoke at least 10 cigarettes daily. We found no evidence of any particular method of nicotine delivery having superior efficacy. We found limited evidence from five RCTs (follow up 2–8 years) that the benefit of nicotine replacement treatment on quit rates decreased with time.

LIKELY TO BE BENEFICIAL

Advice from nurses to quit smoking

One systematic review found limited evidence that advice from nurses to quit smoking increased quitting at 1 year compared with no advice.

Counselling sedentary people to increase physical activity

We found limited evidence from systematic reviews and subsequent RCTs that counselling sedentary people increased physical activity compared with no intervention. Limited evidence from RCTs suggests that consultation with an exercise specialist rather than or in addition to a physician may increase physical activity at 1 year. We found limited evidence that interventions delivered by new media can lead to short term changes in physical activity.

Lifestyle interventions to maintain weight loss

One systematic review and additional RCTs have found that most types of maintenance strategy result in smaller weight gains or greater weight losses compared with no contact. Strategies that involve personal contact with a therapist, family support, walking training programmes, or multiple interventions, or are weight focused, seem most effective.

Self help materials for people who want to stop smoking

One systematic review found that self help materials slightly improved smoking cessation compared with no intervention. It found that individually tailored materials were more effective than standard or stage based materials. One subsequent RCT found no significant difference in abstinence rates at 6 months between self help materials based on the stages of change model and standard self help literature.

Telephone advice to quit smoking

One systematic review found limited evidence that telephone counselling improved quit rates compared with interventions with no personal contact.

UNKNOWN EFFECTIVENESS

Lifestyle advice to prevent weight gain

One small RCT found that low intensity education plus a financial incentive increased weight loss compared with no treatment. A second RCT found no significant effect on prevention of weight gain from a postal newsletter with or without a linked financial incentive compared with no contact. One RCT found that lifestyle advice prevented weight gain in perimenopausal women compared with assessment alone. One small RCT comparing a nutrition course for female students with no nutrition course found no significant increase in weight from baseline in either group at 1 year.

Physical exercise to aid smoking cessation

One systematic review found limited evidence that exercise may increase smoking cessation.

Training health professionals in promoting weight loss

One systematic review of poor quality RCTs provided insufficient evidence on the sustained effect of interventions to improve health professionals' management of obesity. One subsequent cluster RCT found limited evidence that training for primary care doctors in nutrition counselling plus a support programme reduced body weight of the people in their care over 1 year compared with usual care.

Training health professionals to give advice on smoking cessation (increases frequency of antismoking interventions, but may not improve effectiveness)

One systematic review found that training health professionals increased the frequency of antismoking interventions being offered. It found no good evidence that antismoking interventions are more effective if the health professionals delivering the interventions received training. One RCT found that a structured intervention delivered by trained community pharmacists increased smoking cessation rates compared with usual care delivered by untrained community pharmacists.

LIKELY TO BE INEFFECTIVE OR HARMFUL

Acupuncture for smoking cessation

One systematic review found no significant difference between acupuncture and control in smoking cessation rates at 1 year.

Anxiolytics for smoking cessation

One systematic review found no significant difference in quit rates between anxiolytics and control.

DEFINITION Cigarette smoking, diet, and level of physical activity are important in the aetiology of many chronic diseases. Individual change in behaviour has the potential to decrease the burden of chronic disease, particularly cardiovascular disease. This chapter focuses on the evidence that specific interventions lead to changed behaviour.

INCIDENCE/ PREVALENCE In the developed world, the decline in smoking has slowed and the prevalence of regular smoking is increasing in young people. A sedentary lifestyle is becoming increasingly common and the prevalence of obesity is increasing rapidly.

Please refer to the Clinical Evidence website for full text and references.